MDR Tracking Number: M5-04-1006-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-08-03.

The IRO reviewed office visits, electrical stimulation, therapeutic exercises, therapeutic activities, neuromuscular re-education, ultrasound therapy and gait training rendered from 01-13-03 through 05-19-03 that was denied based upon "V".

The IRO concluded that office visits, electrical stimulation, therapeutic exercises, therapeutic activities, neuromuscular re-education, ultrasound therapy rendered from 01-13-03 through 5-19-03 **were** medically necessary. The IRO concluded that gait training rendered from 01-13-03 through 05-19-03 **was not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-24-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
1-15-03	97014	$15.00 (1 unit)	$7.50	H	$15.00	96 MFG MEDICINE GR (I)(9)(a)(ii)	H – Denied pending audit or review. Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
5-22-03	99080	$15.00 (1 unit)	$0.00	NO EOB	$15.00	Rule 133.106(f)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		$30.00	$7.50				The requestor is not entitled to any reimbursement.

This Decision is hereby issued this 3rd day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 01-13-03 through 05-19-03 in this dispute.

This Order is hereby issued this 3rd day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

February 20, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1006-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 53 year-old female who sustained a work related injury on ___. The patient reported that while at work she was unloading a basket when she began to fall. The patient reported that when she attempted to catch herself, she began to experience pain in her right shoulder. A MRI of the right shoulder dated 11/16/00 showed proximal rotator cuff tendonitis, hypertrophic arthropathy of the AC joint and minimal effusion in the shoulder joint and subacromial bursa. On 1/10/01 the patient underwent arthroscopic surgery with synovectomy, chondroplasty, acromioplasty, partial excision of acromioclavicular joint, release of adhesions, open manipulation, electrothermal capsulorrhaphy, rotator cuff repair, and injection of Depo-Medrol and Marcaine of the right shoulder. The patient has undergone EMG/NCV testing on 3/6/01 that indicated normal right upper extremity and borderline right carpal tunnel syndrome. A repeat MRI of the right shoulder on 6/3/02 showed abnormal appearance of both the supraspinatus and infraspinatus components of the rotator cuff apparatus, and impingement at the level of the inferior margin of the acromioclavicular joint with parital obliteration of the subacromial fat pad. The diagnoses for this patient have included internal derangement of the right shoulder, impingement syndrome right shoulder, and traumatic arthritis right shoulder, failed conservative treatment. The patient has been treated with physical therapy, chiropractic manipulations, oral medications and a work hardening program.

Requested Services

Office visits, electrical stimulation, therapeutic exercises, therapeutic activities, neuromuscular reeducation, ultrasound therapy, gait training from 1/13/03 through 5/19/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 53 year-old female who sustained a work related injury to her right shoulder on ___. The ___ chiropractor reviewer indicated that an MRI of the right shoulder dated 11/16/00 showed proximal rotator cuff tendonitis, hypertrophic arthropathy of the AC joint and minimal effusion in the shoulder joint and subacromial bursa. The ___ chiropractor reviewer noted that the patient had undergone two shoulder surgeries however still experiences loss of strength and function in the right shoulder.

The ___ chiropractor reviewer explained that this patient has an adhesive capsulitis that is going to require periodic therapeutic intervention depending on this patient's symptoms.

The ___ chiropractor reviewer indicated that the treatment provided in 1/03 and 2/03, and again in 4/03 and 5/03, was beneficial in reducing this patient's pain and helped restore function. The ___ chiropractor reviewer explained that the patient met the goals of the healthcare provider during the treatment sessions. However, the ___ chiropractor reviewer also explained that the gait training this patient received was not medically necessary to treat her right shoulder injury. Therefore, the ___ chiropractor consultant concluded that the office visits; electrical stimulation, therapeutic exercises, therapeutic activities, neuromuscular reeducation, and ultrasound therapy from 1/13/03 through 5/19/03 were medically necessary. However, the ___ chiropractor consultant also concluded that the gait training from 1/13/03 through 5/19/03 were not medically necessary to treat this patient's condition.

Sincerely,